Complete Summary

GUIDELINE TITLE

Screening for syphilis infection in pregnancy: U.S. Preventive Services Task Force reaffirmation recommendation statement.

BIBLIOGRAPHIC SOURCE(S)

U.S. Preventive Services Task Force. Screening for syphilis infection in pregnancy: U.S. Preventive Services Task Force reaffirmation recommendation statement. Ann Intern Med 2009 May 19;150(10):705-9. PubMed

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Syphilis

GUIDELINE CATEGORY

Prevention
Screening

CLINICAL SPECIALTY

Family Practice
Internal Medicine

Obstetrics and Gynecology
Pediatrics

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Nurses
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

- To reaffirm the 2004 recommendations on screening for syphilis in pregnancy
- To summarize the U.S. Preventive Services Task Force recommendations and update the evidence on screening pregnant women for syphilis infection

TARGET POPULATION

Pregnant women seen in primary care settings

INTERVENTIONS AND PRACTICES CONSIDERED

Screening for syphilis using nontreponemal tests (Venereal Disease Research Laboratory [VDRL] or Rapid Plasma Reagin [RPR], followed by confirmatory fluorescent treponemal antibody absorbed test (FTA-ABS) or *Treponema pallidum* particle agglutination test (TPPA)

MAJOR OUTCOMES CONSIDERED

- **Key Question 1**: Does screening for syphilis in pregnancy reduce the prevalence of congenital syphilis in neonates?
- **Key Question 2**: Are there harms of screening for syphilis or harms of treatment with penicillin in pregnancy to women or neonates?

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): A targeted review of the literature was prepared by the Agency for Healthcare Research and Quality (AHRQ) for use by the U.S. Preventive Services Task Force (USPSTF) (see the "Availability of Companion Documents" field).

Data Sources and Searches

AHRQ staff performed literature searches on the benefits and harms of screening for syphilis infection in pregnant women, as well as the harms of penicillin treatment for this infection in pregnant women and in neonates. Searches were limited to the period of 1 January 2003 through 31 July 2008 and the search terms used were *penicillin*, *pregnancy*, *infant*, *newborn*, *fetus*, *adverse effect, allergic reaction, harm, mass screening, rapid plasma reagin, VDRL antigen, pregnancy complications, Treponema pallidum*, and *syphilis*. Initial searches were limited to English-language articles that were indexed in the PubMed core clinical journal subset (formerly known as the Abridged Index Medicus). AHRQ staff supplemented these searches by reviewing reference lists of important articles and recent reviews and by taking suggestions from experts.

Study Selection

AHRQ staff selected studies that provided evidence on the benefits of screening for syphilis in pregnancy in the reduction of incidence of congenital syphilis; the harms of screening, specifically focusing on false-positive and false-negative results; and the harms of treatment, primarily allergic reactions and fetal harms. For evidence on benefits, studies that included pregnant women were selected. For evidence on false-positive and false-negative results, AHRQ staff included studies in pregnant and nonpregnant adults who were screened with the Rapid Plasma Reagin (RPR) or Venereal Disease Research Laboratory (VDRL) test and used treponemal-specific tests as the gold standard. Studies that reported only results for newer rapid tests and did not report results on RPR and VDRL, which are considered the standard of care in the United States, were excluded. For evidence on allergic reactions to penicillin, studies that included pregnant and nonpregnant adults were selected. Studies in high-risk or special populations and studies in populations not generalizable to the United States were excluded. AHRQ staff determined generalizability of study sample to the United States by consensus of 2 reviewers after discussions with the USPSTF on similarities between the health care system in the study country and that of the United States. Considerations about whether a population would be comparable to a U.S. population include the general health status of the population, the availability of prenatal care, and the availability of trained delivery attendants. Studies in populations with high human immunodeficiency virus (HIV) rates were specifically excluded, because these studies are thought not to be generalizable to the United States.

To determine whether prenatal screening reduces the prevalence of congenital syphilis in neonates, randomized, controlled trials; meta-analyses; and systematic reviews were included. In addition, large ecologic studies and cohort studies that reported the effect of the implementation of widespread screening programs were included. AHRQ staff included these types of studies because the original evidence on the effectiveness of syphilis screening in pregnancy was from ecologic studies that showed that rates of congenital syphilis were reduced after widespread screening and treatment. To determine the harms of syphilis screening and penicillin treatment, randomized, controlled trials; meta-analyses; systematic reviews; cohort studies; case-control studies; and large case series were included. Editorials, narrative reviews, case studies, and guideline reports were excluded.

At the abstract and full article review stage, 2 reviewers independently evaluated all articles according to predetermined exclusion criteria. Any article selected by at least 1 reviewer at the abstract stage was advanced to the full article stage of the review. Differences of opinion were resolved at the full article stage by consensus and involved a third reviewer if necessary.

NUMBER OF SOURCE DOCUMENTS

141 potentially relevant studies were identified. After studies were excluded based on predetermined criteria, 5 studies remained—1 study of the benefits of screening and 4 studies of the harms of screening and treatment.

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): A targeted review of the literature was prepared by the Agency for Healthcare Research and Quality (AHRQ) for use by the U.S. Preventive Services Task Force (USPSTF) (see the "Availability of Companion Documents" field).

Data Extraction

Information was extracted from each included study on its design, selection criteria, demographic characteristics, and clinical outcomes.

Quality Appraisal

AHRQ staff provided narrative descriptions of key methodological deficiencies of included studies that constrain the quality and generalizability of the evidence.

Data Synthesis

Evidence from included studies was synthesized in a narrative format.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Balance Sheets
Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The U.S. Preventive Services Task Force (USPSTF) systematically reviews the evidence concerning both the benefits and harms of widespread implementation of a preventive service. It then assesses the certainty of the evidence and the magnitude of the benefits and harms. On the basis of this assessment, the USPSTF assigns a letter grade to each preventive service signifying its recommendation about provision of the service (see Table below). An important, but often challenging, step is determining the balance between benefits and harms to estimate "net benefit" (that is, benefits minus harms).

Table 1. U.S. Preventive Services Task Force Recommendation Grid*

Certainty of Net Benefit	Magnitude of Net Benefit			
	Substantial	**Moderate**	**Small**	**Zero/Negative**
High	A	B	C	D
Moderate	B	B	C	D
Low	Insufficient			

**A*, *B*, *C*, *D*, and *I (Insufficient)* represent the letter grades of recommendation or statement of insufficient evidence assigned by the U.S. Preventive Services Task Force after assessing certainty and magnitude of net benefit of the service (see the "Rating Scheme for the Strength of the Recommendations" field).

The overarching question that the Task Force seeks to answer for every preventive service is whether evidence suggests that provision of the service would improve health outcomes if implemented in a general primary care population. For screening topics, this standard could be met by a large randomized, controlled trial (RCT) in a representative asymptomatic population with follow-up of all members of both the group "invited for screening" and the group "not invited for screening."

Direct RCT evidence about screening is often unavailable, so the Task Force considers indirect evidence. To guide its selection of indirect evidence, the Task Force constructs a "chain of evidence" within an analytic framework. For each key question, the body of pertinent literature is critically appraised, focusing on the following 6 questions:

1. Do the studies have the appropriate research design to answer the key question(s)?
2. To what extent are the existing studies of high quality? (i.e., what is the internal validity?)
3. To what extent are the results of the studies generalizable to the general U.S. primary care population and situation? (i.e., what is the external validity?)
4. How many studies have been conducted that address the key question(s)? How large are the studies? (i.e., what is the precision of the evidence?)
5. How consistent are the results of the studies?
6. Are there additional factors that assist us in drawing conclusions (e.g., presence or absence of dose–response effects, fit within a biologic model)?

The next step in the Task Force process is to use the evidence from the key questions to assess whether there would be net benefit if the service were implemented. In 2001, the USPSTF published an article that documented its systematic processes of evidence evaluation and recommendation development. At that time, the Task Force's overall assessment of evidence was described as good, fair, or poor. The Task Force realized that this rating seemed to apply only to how well studies were conducted and did not fully capture all of the issues that go into an overall assessment of the evidence about net benefit. To avoid confusion, the USPSTF has changed its terminology. Whereas individual study quality will continue to be characterized as good, fair, or poor, the term *certainty* will now be used to describe the Task Force's assessment of the overall body of evidence about net benefit of a preventive service and the likelihood that the assessment is correct. Certainty will be determined by considering all 6 questions listed above; the judgment about certainty will be described as high, moderate, or low.

In making its assessment of certainty about net benefit, the evaluation of the evidence from each key question plays a primary role. It is important to note that the Task Force makes recommendations for real-world medical practice in the United States and must determine to what extent the evidence for each key question—even evidence from screening RCTs or treatment RCTs—can be applied to the general primary care population. Frequently, studies are conducted in highly selected populations under special conditions. The Task Force must consider differences between the general primary care population and the populations studied in RCTs and make judgments about the likelihood of observing the same effect in actual practice.

It is also important to note that 1 of the key questions in the analytic framework refers to the potential harms of the preventive service. The Task Force considers the evidence about the benefits and harms of preventive services separately and equally. Data about harms are often obtained from observational studies because harms observed in RCTs may not be representative of those found in usual practice and because some harms are not completely measured and reported in RCTs.

Putting the body of evidence for all key questions together as a chain, the Task Force assesses the certainty of net benefit of a preventive service by asking the 6 major questions listed above. The Task Force would rate a body of convincing evidence about the benefits of a service that, for example, derives from several RCTs of screening in which the estimate of benefits can be generalized to the general primary care population as "high" certainty (see the "Rating Scheme for the Strength of Recommendations" field). The Task Force would rate a body of evidence that was not clearly applicable to general practice or has other defects in quality, research design, or consistency of studies as "moderate" certainty. Certainty is "low" when, for example, there are gaps in the evidence linking parts of the analytic framework, when evidence to determine the harms of treatment is unavailable, or when evidence about the benefits of treatment is insufficient. Table 4 in the methodology document listed below (see "Availability of Companion Documents" field) summarizes the current terminology used by the Task Force to describe the critical assessment of evidence at all 3 levels: individual studies, key questions, and overall certainty of net benefit of the preventive service.

Sawaya GF et al., Update on the methods of the U.S. Preventive Services Task Force: estimating certainty and magnitude of net benefit. Ann Intern Med. 2007;147:871-875.[5 references].

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

What the United States Preventive Services Task Force (USPSTF) Grades Mean and Suggestions for Practice

Grade	Grade Definitions	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer or provide this service.
B	The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.	Offer or provide this service.
C	The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is moderate or high certainty that the net benefit is small.	Offer or provide this service only if there are other considerations in support of the offering/providing the service in an individual patient.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
I Statement	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality or conflicting, and the balance of benefits and harms cannot be determined.	Read "Clinical Considerations" section of USPSTF Recommendation Statement (see "Major Recommendations" field). If offered, patients should understand the uncertainty about the balance of benefits and harms.

USPSTF Levels of Certainty Regarding Net Benefit

Definition: The U.S. Preventive Services Task Force defines certainty as "likelihood that the USPSTF assessment of the net benefit of a preventive service is correct." The net benefit is defined as benefit minus harm of the preventive service as implemented in a general, primary care population. The USPSTF assigns a certainty level based on the nature of the overall evidence available to assess the net benefit of a preventive service.

Level of Certainty	Description
High	The available evidence usually includes consistent results from well-

Level of Certainty	Description
	designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.
Moderate	The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by factors such as: • The number, size, or quality of individual studies • Inconsistency of findings across individual studies • Limited generalizability of findings to routine primary care practice • Lack of coherence in the chain of evidence As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion.
Low	The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of: • The limited number or size of studies • Important flaws in study design or methods • Inconsistency of findings across individual studies • Gaps in the chain of evidence • Findings not generalizable to routine primary care practice • A lack of information on important health outcomes More information may allow an estimation of effects on health outcomes.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Comparison with Guidelines from Other Groups
External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Peer Review. Before the U.S. Preventive Services Task Force makes its final determinations about recommendations on a given preventive service, the Evidence-Based Practice Center and the Agency for Healthcare Research and Quality send a draft evidence review to 4 to 6 external experts and to federal agencies and professional and disease-based health organizations with interests in the topic. They ask the experts to examine the review critically for accuracy and completeness and to respond to a series of specific questions about the

document. After assembling these external review comments and documenting the proposed response to key comments, the topic team presents this information to the Task Force in memo form. In this way, the Task Force can consider these external comments before it votes on its recommendations about the service. Draft recommendation statements are then circulated for comment from reviewers representing professional societies, voluntary organizations and Federal agencies. These comments are discussed before the final recommendations are confirmed.

Recommendation of Others. Recommendations for screening pregnant women for syphilis from the following groups were discussed: Centers for Disease Control and Prevention, the American Academy of Family Physicians, the American Academy of Pediatrics, and the American College of Obstetricians and Gynecologists.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The US Preventive Services Task Force (USPSTF) grades its recommendations (A, B, C, D, or I) and identifies the Levels of Certainty regarding Net Benefit (High, Moderate, and Low). The definitions of these grades can be found at the end of the "Major Recommendations" field.

Summary of Recommendations and Evidence

The USPSTF recommends that clinicians screen all pregnant women for syphilis infection. **This is a grade A recommendation**.

Clinical Considerations

Patient Population Under Consideration

This recommendation applies to pregnant women.

Assessment of Risk

Pregnant women who are at increased risk for syphilis infection include uninsured women, women living in poverty, sex workers, illicit drug users, and other women living in communities with high syphilis morbidity. The prevalence of syphilis infection differs by region (it is higher in the southern United States and in some metropolitan areas than it is in the United States as a whole) and by ethnicity (it is higher in Hispanic and African-American populations than in the white population). Persons in whom sexually transmitted diseases have been diagnosed may be more likely than others to engage in high-risk behavior, which places them at increased risk for syphilis.

Screening Tests

Nontreponemal tests commonly used for initial screening are the Venereal Disease Research Laboratory (VDRL) test or the Rapid Plasma Reagin (RPR) test. These are typically followed by a confirmatory fluorescent treponemal antibody absorbed test or *Treponema pallidum* particle agglutination test (TPPA).

Treatment

The Centers for Disease Control and Prevention (CDC) has outlined appropriate treatment of syphilis in pregnancy (www.cdc.gov/std/treatment/). In its 2006 sexually transmitted disease treatment guidelines, the CDC recommends parenteral benzathine penicillin G for the treatment of syphilis in pregnancy. Evidence on the efficacy or safety of alternative antibiotics in pregnancy is limited; therefore, women who report penicillin allergies should be evaluated for penicillin allergies and, if present, desensitized and treated with penicillin. Because the CDC updates these recommendations regularly, clinicians are encouraged to access the CDC Web site (www.cdc.gov/std/treatment/) to obtain the most up-to-date information.

Screening Intervals

All pregnant women should be tested at their first prenatal visit. For women in high-risk groups, many organizations recommend repeat serologic testing in the third trimester and at delivery. Most states mandate that all pregnant women be screened at some point during pregnancy, and many mandate screening at the time of delivery. Follow-up serologic tests should be obtained after treatment to document decline in titers. To ensure that results are comparable, follow-up tests should be performed by using the same nontreponemal test that was used initially to document the infection (for example, VDRL or RPR).

Useful Resources

The USPSTF has made recommendations on screening for other sexually transmitted diseases in pregnancy, including gonorrhea, chlamydial infection, hepatitis B, herpes, and human immunodeficiency virus (HIV). Please see the USPSTF Web site (www.preventiveservices.ahrq.gov) for more information on these recommendations. The CDC guidelines on treatment for syphilis in pregnancy can be accessed at www.cdc.gov/std/treatment/.

Definitions:

What the United States Preventive Services Task Force (USPSTF) Grades Mean and Suggestions for Practice

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Grade	Grade Definitions	Suggestions for Practice
	benefit is moderate to substantial.	
C	The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is moderate or high certainty that the net benefit is small.	Offer or provide this service only if there are other considerations in support of the offering/providing the service in an individual patient.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
I Statement	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality or conflicting, and the balance of benefits and harms cannot be determined.	Read "Clinical Considerations" section of USPSTF Recommendation Statement (see "Major Recommendations" field). If offered, patients should understand the uncertainty about the balance of benefits and harms.

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High	The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.
Moderate	The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by factors such as: • The number, size, or quality of individual studies • Inconsistency of findings across individual studies • Limited generalizability of findings to routine primary care practice • Lack of coherence in the chain of evidence As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough

Level of Certainty	Description
	to alter the conclusion.
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CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Benefits of Detection and Early Treatment

The U.S. Preventive Services Task Force (USPSTF) found convincing observational evidence that the universal screening of pregnant women decreases the proportion of infants with clinical manifestations of syphilis infection.

POTENTIAL HARMS

Harms of Detection and Early Treatment

Screening and treatment may result in potential harms, including false-positive results that require clinical evaluation, unnecessary anxiety to the patient, and harms of antibiotic use. However, the U.S. Preventive Services Task Force (USPSTF) concluded that the harm from screening is no greater than small.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- The U.S. Preventive Services Task Force (USPSTF) makes recommendations about preventive care services for patients without recognized signs or symptoms of the target condition.
- Recommendations are based on a systematic review of the evidence of the benefits and harms and an assessment of the net benefit of the service.
- The USPSTF recognizes that clinical or policy decisions involve more considerations than this body of evidence alone. Clinicians and policy-makers should understand the evidence but individualize decision making to the specific patient or situation.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The experiences of the first and second U.S. Preventive Services Task Force (USPSTF), as well as that of other evidence-based guideline efforts, have highlighted the importance of identifying effective ways to implement clinical recommendations. Practice guidelines are relatively weak tools for changing clinical practice when used in isolation. To effect change, guidelines must be coupled with strategies to improve their acceptance and feasibility. Such strategies include enlisting the support of local opinion leaders, using reminder systems for clinicians and patients, adopting standing orders, and audit and feedback of information to clinicians about their compliance with recommended practice.

In the case of preventive services guidelines, implementation needs to go beyond traditional dissemination and promotion efforts to recognize the added patient and clinician barriers that affect preventive care. These include clinicians' ambivalence about whether preventive medicine is part of their job, the psychological and practical challenges that patients face in changing behaviors, lack of access to health care or of insurance coverage for preventive services for some patients, competing pressures within the context of shorter office visits, and the lack of organized systems in most practices to ensure the delivery of recommended preventive care.

Dissemination strategies have changed dramatically in this age of electronic information. While recognizing the continuing value of journals and other print formats for dissemination, the Agency for Healthcare Research and Quality will make all U.S. Preventive Services Task Force (USPSTF) products available through its Web site. The combination of electronic access and extensive material in the public domain should make it easier for a broad audience of users to access U.S. Preventive Services Task Force materials and adapt them for their local needs. Online access to U.S. Preventive Services Task Force products also opens up new possibilities for the appearance of the annual, pocket-size *Guide to Clinical Preventive Services*.

To be successful, approaches for implementing prevention have to be tailored to the local level and deal with the specific barriers at a given site, typically requiring the redesign of systems of care. Such a systems approach to prevention has had notable success in established staff-model health maintenance organizations, by addressing organization of care, emphasizing a philosophy of prevention, and

altering the training and incentives for clinicians. Staff-model plans also benefit from integrated information systems that can track the use of needed services and generate automatic reminders aimed at patients and clinicians, some of the most consistently successful interventions. Information systems remain a major challenge for individual clinicians' offices, however, as well as for looser affiliations of practices in network-model managed care and independent practice associations, where data on patient visits, referrals, and test results are not always centralized.

IMPLEMENTATION TOOLS

Foreign Language Translations
Patient Resources
Personal Digital Assistant (PDA) Downloads
Pocket Guide/Reference Cards
Staff Training/Competency Material

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

U.S. Preventive Services Task Force. Screening for syphilis infection in pregnancy: U.S. Preventive Services Task Force reaffirmation recommendation statement. Ann Intern Med 2009 May 19;150(10):705-9. PubMed

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2009

GUIDELINE DEVELOPER(S)

United States Preventive Services Task Force - Independent Expert Panel

GUIDELINE DEVELOPER COMMENT

The U.S. Preventive Services Task Force (USPSTF) is a federally-appointed panel of independent experts. Conclusions of the U.S. Preventive Services Task Force do not necessarily reflect policy of the U.S. Department of Health and Human Services (DHHS) or its agencies.

SOURCE(S) OF FUNDING

United States Government

GUIDELINE COMMITTEE

U.S. Preventive Services Task Force (USPSTF)

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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**Member of the USPSTF at the time this recommendation was finalized.* For a list of current Task Force members, go to www.ahrq.gov/clinic/uspstfab.htm.

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

The U.S. Preventive Services Task Force has an explicit policy concerning conflict of interest. All members disclose at each meeting if they have a significant financial, professional/business, or intellectual conflict for each topic being discussed. Task Force members with conflicts may be recused from discussing or voting on recommendations about the topic in question.

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site and the Annals of Internal Medicine Web site.

Print copies: Available from the Agency for Healthcare Research and Quality (AHRQ) Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

Evidence Reviews:

- Wolff T, Shelton E, Sessions C, Miller T. Screening for syphilis infection in pregnant women: evidence for the U.S. Preventive Services Task Force reaffirmation recommendation statement. Ann Intern Med 2009;150:710-716. Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site and the Annals of Internal Medicine Web site.

The following are also available:

- Screening for syphilis infection in pregnancy: clinical summary of U.S. Preventive Services Task Force recommendation. Rockville (MD): Agency for Healthcare Research and Quality, 2009. Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site.
- A continuing medical education (CME) activity is available from the Annals of Internal Medicine Web site.

Background Articles:

- Barton M et al. How to read the new recommendation statement: methods update from the U.S. Preventive Services Task Force. Ann Intern Med. 2007;147:123-127.
- Guirguis-Blake J et al. Current processes of the U.S. Preventive Services Task Force: refining evidence-based recommendation development. Ann Intern Med. 2007;147:117-122. [2 references]
- Sawaya GF et al., Update on the methods of the U.S. Preventive Services Task Force: estimating certainty and magnitude of net benefit. Ann Intern Med. 2007;147:871-875. [5 references].
- Petitti DB, Teutsch SM, Barton MB, Sawaya GF, Ockene JK, DeWitt T. Update on the methods of the U.S. Preventive Services Task Force: insufficient evidence. Ann Intern Med. 2009;150:199-205.

Electronic copies: Available from U.S. Preventive Services Task Force (USPSTF) Web site.

Print copies: Available from the Agency for Healthcare Research and Quality Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).

The Electronic Preventive Services Selector (ePSS), available as a PDA application and a web-based tool, is a quick hands-on tool designed to help primary care clinicians identify the screening, counseling, and preventive medication services that are appropriate for their patients. It is based on current recommendations of the USPSTF and can be searched by specific patient characteristics, such as age, sex, and selected behavioral risk factors.

PATIENT RESOURCES

The following are available:

- Women: stay healthy at any age. Your checklist for health. Rockville (MD): Agency for Healthcare Research and Quality. AHRQ Pub. No. 07-IP005-A. February 2007. Electronic copies: Available from the USPSTF Web site. See the related QualityTool summary on the Health Care Innovations Exchange Web site.

Print copies: Available in English and Spanish from the Agency for Healthcare Research and Quality (AHRQ) Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).

My healthfinder is a new tool that provides personalized recommendations for clinical preventive services specific to the user's age, gender, and pregnancy status. It features evidence-based recommendations from the USPSTF and is available at www.healthfinder.gov.

The following is also available:

- Screening pregnant women for syphilis infection: U.S. Preventive Services Task Force Recommendation. Summaries for patients. Ann Intern Med. 2009;150(10):I-40. Available from the Annals of Internal Medicine Web site.

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